

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10628

1. PLACE OF DEATH o. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Queen Anns</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chester River Beach</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHESTER</u> Middle <u>F.</u> Last <u>ARMSTRONG</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>23</u> Year <u>19 59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 23, 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-05-4773</u>	
17. INFORMANT <u>Mrs. Helen P. Armstrong - 36 C Chester River</u>		Address <u>Grasonville, Md. Beach</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Broncho Pneumonia</u> 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>AMYOTROPHIC LATERAL SCHROSIS</u> DUE TO (c) <u>Indef</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8-20-59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-14-59</u> , 19 <u>59</u> , to <u>9-21-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-21-59</u> , 19 <u>59</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Luigi Baldi M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>LUIGI BALDI, M.D.</u>		<u>CHESTER, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/26/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Tichenor & Sons. Balto. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

NAME OF DECEASED _____		SEX _____	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF DEATH _____		NAME OF PHYSICIAN _____	
NAME OF FUNERAL HOME _____		NAME OF BURIAL PLACE _____	
NAME OF NEXT OF KIN _____		NAME OF WITNESS _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF FUNERAL HOME _____		SIGNATURE OF BURIAL PLACE _____	
SIGNATURE OF NEXT OF KIN _____		SIGNATURE OF WITNESS _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF FUNERAL HOME _____		SIGNATURE OF BURIAL PLACE _____	
SIGNATURE OF NEXT OF KIN _____		SIGNATURE OF WITNESS _____	



This certificate is valid only when countersigned by the proper authorities of the State Department of Health, Baltimore, 18.

10646

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Centerville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1315 Chesterfield Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM MARVIN BARTON</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>2</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 11-1888</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refined</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant Cabinet Maker</u>		11. BIRTHPLACE (State or foreign country) <u>Queen Anne's Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William James Barton</u>				14. MOTHER'S MAIDEN NAME <u>Louella M. Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-32-1287</u>		17. INFORMANT <u>Elizabeth J Barton</u> Address <u>Centerville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL ARTERIO SCLEROSIS</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 WEEKS</u> <u>5-10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>22 AUGUST, 19 59</u> to <u>2 SEPT, 19 59</u> , that I last saw the deceased alive on <u>22 AUGUST, 19 59</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James Kent Young</u> M.D.				ADDRESS (Street, city or town, state) <u>105 CHESTERFIELD AVE. CENTREVILLE, MARYLAND</u>			
PHYSICIAN'S NAME (Type) <u>James Kent Young</u>				DATE SIGNED <u>9/2/59</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 4-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Barton</u> ADDRESS <u>Barton Bros Centerville Md</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Item 7 Film G249 9-30-59 et
10647
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10630

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sudlersville</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - xxxxxxxxxxxx Sudlersville</u>		d. STREET ADDRESS <u>Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Jefferson</u> Last <u>Esperson</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> , Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 12, 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumber</u>	
11. BIRTHPLACE (State or foreign country) <u>Brooklyn New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Esperson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Jefferson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Elfreida Esperson - Sudlersville, Md.</u>		Address <u>RFD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Fracture</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiparesis 4/25/59</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>7</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Sept 25</u> , 19 <u>59</u> , to <u>Sept 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 25</u> , 19 <u>59</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sudlersville, Md.</u> DATE SIGNED <u>9/26/59</u> ACTUAL SIGNATURE <u>C. H. Metcalfe</u> M.D. PHYSICIAN'S NAME (Type) <u>C. H. Metcalfe</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Patchogue - Suffolk County N. Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wells Wells</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10648

CERTIFICATE OF DEATH

10631

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown 1437-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Alice Wright Nursing Home				d. STREET ADDRESS 1437-2			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E. Last JOHNSON				4. DATE OF DEATH Month September Day 24 Year 19 59			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH No family record		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Johnson				14. MOTHER'S MAIDEN NAME Matilda Glenn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hattie Johnson, Chestertown, Md. R.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute heart failure 450.0 DUE TO Sclerosis of the arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Urine retention (Prostatic Tumors) (b) (c) INTERVAL BETWEEN ONSET AND DEATH one day 10 years 2						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 12 , 19 59 , to Sept. 24 , 19 59 , that I last saw the deceased alive on Sept 23 , 19 59 , and that death occurred at 3:40 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Geza Koralewski M.D.				ADDRESS (Street, city or town, state) MILLINGTON, MD DATE SIGNED 9-25-59			
PHYSICIAN'S NAME (Type) GEZA KORALEWSKI							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 26, 1959		22c. NAME OF CEMETERY OR CREMATORY Emmanuel M.E. Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Rural. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Hellous, Millington, Md.				24a. REC'D BY REGISTRAR SEP 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10649

CERTIFICATE OF DEATH

Reg. Dist. No.

10632

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington		c. LENGTH OF STAY IN 1b Rural Centreville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Alice Wright Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JANIE Middle MURRAY Last MURRAY		4. DATE OF DEATH Month September Day 26 Year 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1875
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown Porter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Alice Wright,		Address Rural Millington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Degeneration of the heart muscle (c) years.			INTERVAL BETWEEN ONSET AND DEATH 2 days years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 24, 19 59 to Sept. 26, 19 59 , that I last saw the deceased alive on Sept 25, 19 59 , and that death occurred at 7:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE GEZA KORALEWSKI, MD		ADDRESS (Street, city or town, state) MILLINGTON, MD DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 28, 1959	
22c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		22d. LOCATION (City, town, or county) (State) Centreville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Hollows, Millington Md.		24a. REC'D BY REGISTRAR DATE SEP 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur G. Hines			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
10650 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 10633										
1. PLACE OF DEATH a. COUNTY <u>Queen Anne's County</u> <u>Centreville</u> <u>Grove Creek</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Q A</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>			c. LENGTH OF STAY IN 1b <u>—</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill, Md</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>					d. STREET ADDRESS <u>1</u>					
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>Medford</u> Last <u>Porter</u>					4. DATE OF DEATH Month <u>Sept</u> Day <u>20</u> Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 25, 1906</u>		9. AGE (In years last birthday) <u>53</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive</u>		11. BIRTHPLACE (State or foreign country) <u>Queen Anne's Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				
13. FATHER'S NAME <u>Miffitt Porter</u>					14. MOTHER'S MAIDEN NAME <u>Harriet Chance</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>216-09-7770</u>		17. INFORMANT Address <u>Mrs Edith Porter</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>353.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Epilepsy</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>15-30 min</u> <u>30 year</u>										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Had Epileptic Seizure & fell in River</u>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>9 30</u> <u>20</u> <u>1959</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Grove Creek</u>		20f. (City or town) (County) (State) <u>Centreville Q.A. Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>C. R. Layton</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>C. R. Layton</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 23</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL</u>			22d. LOCATION (City, town, or county) (State) <u>CHURCH HILL MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>					ADDRESS <u>Church Hill Md.</u>		24a. REC'D BY REGISTRAR <u>Sept 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. R. Layton</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF DEATH [Faint text, possibly "10/15/1918"]	
PLACE OF DEATH [Faint text, possibly "Home"]		CITY [Faint text, possibly "Baltimore"]	
STREET [Faint text, possibly "123 Main St"]		COUNTY [Faint text, possibly "Baltimore"]	
STATE [Faint text, possibly "Maryland"]		ZIP CODE [Faint text, possibly "21201"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
MANNER OF DEATH [Faint text, possibly "Natural"]		MEDICAL HISTORY [Faint text, possibly "Hypertension"]	
PREVIOUS ILLNESS [Faint text, possibly "None"]		MEDICATION [Faint text, possibly "None"]	
SIGNATURE OF EXAMINER [Faint signature]		SIGNATURE OF DECEASED [Faint signature]	
DATE OF EXAMINATION [Faint text, possibly "10/15/1918"]		TIME OF EXAMINATION [Faint text, possibly "10:00 AM"]	
PLACE OF EXAMINATION [Faint text, possibly "Home"]		CITY [Faint text, possibly "Baltimore"]	
STREET [Faint text, possibly "123 Main St"]		COUNTY [Faint text, possibly "Baltimore"]	
STATE [Faint text, possibly "Maryland"]		ZIP CODE [Faint text, possibly "21201"]	

RECEIVED
 OCT 16 1918
 BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10651

CERTIFICATE OF DEATH

10634

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barclay Rural		c. LENGTH OF STAY IN 1b 10 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) GEORGE First W. Middle SATTERFIELD Last		4. DATE OF DEATH 9 Month 17 Day 19 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-1874
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Satterfield		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, specify or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Aldrich Satterfield Address Sudlersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sclerosis of the blood vessels. (c) Senile debility		INTERVAL BETWEEN ONSET AND DEATH 2 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 12 , 19 59 , to Sept 17 , 19 59 , that I last saw the deceased alive on Sept. 16 , 19 59 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Geza Koralewski		ADDRESS (Street, city or town, state) MILINGTON, MD	
PHYSICIAN'S NAME (Type) GEZA KORALEWSKI		DATE SIGNED 9.18.59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-59	
22c. NAME OF CEMETERY OR CREMATORY Busic		22d. LOCATION (City, town, or county) (State) Barclay, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.E. Boula's Greensboro, Md.		24a. REC'D BY REGISTRAR DATE SEP 21 '59	
		24b. REGISTRAR'S SIGNATURE Arthur & Thana	

CERTIFICATE OF DEATH

10051

1. NAME OF DECEASED JOSEPH H. BARTLETT		2. SEX Male		3. AGE 78		4. RACE White		5. PLACE OF BIRTH St. Louis, Mo.	
6. DATE OF DEATH Dec 10, 1950		7. TIME OF DEATH 10:30 AM		8. PLACE OF DEATH Home		9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural	
11. I certify that I observed the deceased from		12. I certify that I observed the deceased from		13. I certify that I observed the deceased from		14. I certify that I observed the deceased from		15. I certify that I observed the deceased from	
16. I certify that I observed the deceased from		17. I certify that I observed the deceased from		18. I certify that I observed the deceased from		19. I certify that I observed the deceased from		20. I certify that I observed the deceased from	
21. I certify that I observed the deceased from		22. I certify that I observed the deceased from		23. I certify that I observed the deceased from		24. I certify that I observed the deceased from		25. I certify that I observed the deceased from	
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96. I certify that I observed the deceased from		97. I certify that I observed the deceased from		98. I certify that I observed the deceased from		99. I certify that I observed the deceased from		100. I certify that I observed the deceased from	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. IT IS NOT VALID FOR ANY OTHER PURPOSES.